# DHHS FY2004 BUDGET PRIORITIES: MEDICARE AND MEDICAID

**Testimony**

***Presented To***

## THE COMMITTEE ON THE BUDGET

## UNITED STATES HOUSE OF REPRESENTATIVES

**By**

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Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation and I am also Co-Chair of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. I have previously served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses the Administration's proposals for Medicare and prescription drug coverage, the need for reforming Medicare, the Administration's proposal to provide optional Medicaid and SCHIP funding and flexibility and the rationale for these changes to Medicaid.

**The Administration's Medicare Proposals**

The Administration has proposed to modernize and reform Medicare with a program that will include $400 billion in net additional spending. Although the details are not yet available, the principles for strengthening and improving Medicare are part of the budget. The reformed Medicare program would include an improved traditional fee-for-service plan and more varied health insurance options, so that ultimately Medicare would look more like the Federal Employees Health Benefits Program (FEHBP). Some of the important principles underlying the reform include giving all seniors the option of a subsidized drug benefit, providing better

coverage for preventive care, allowing seniors to keep traditional Medicare, providing better options to traditional Medicare, strengthening the program's financial security and streamlining Medicare's regulations and administrative procedures.

The Administration is also proposing a variety of strategies to improve Medicare in the short term including changes to the pricing of the Medicare+Choice program, changing the reimbursement for outpatient drugs, providing better information of the quality of care delivered in hospitals and nursing homes and improving the appeals process for beneficiaries and providers.

**The Need to Reform Medicare**

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors have access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. These include complaints of inadequate benefits from the beneficiaries, concerns of long-term financial solvency by legislators and criticisms from the provider community of inadequate payments and excessive administrative complexity.

Part of the motivation for Medicare reform has clearly been financial. The financial challenges to Medicare are well known and are documented annually in the Medicare Trustees report made public each spring. Medicare is currently spending about $250 billion for 39 million aged and disabled Americans and spending on Medicare is expected to grow at a rate of about 7 percent

per year for the next decade. This rate is substantially faster than the rate of economic growth and than the growth in federal revenues.

The long-term outlook for Medicare is primarily driven by demographics. The changing demographics associated with the retirement of 78 million baby-boomers between the years of 2010 and 2030, the expected longevity of the boomers, and the relatively smaller cohorts from the baby-bust generation means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline. The strong economy of the last decade and the slow growth in Medicare expenditures for FY 1998-2000 has provided more years of solvency than was initially projected, but even so, Part A of the Trust Fund, which is financed by a portion of the wage tax, is expected to face cash flow deficits as soon as 2016.

As important as issues of Part A solvency are, however, the frequent focus on Part A as a reflection of Medicare's fiscal health is unhelpful and misleading. Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially faster than Part A and much faster than the economy as a whole. This means that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling for Part B expenditures will mean fewer dollars available to support other government programs.

However, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960's. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made as well as other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

The most publicized problem of Medicare is its outdated benefit package. Unlike almost any other health plan that would be purchased today, Medicare effectively has no outpatient prescription drug coverage and no protection against very large medical bills. As a result, most seniors have supplemented traditional Medicare although some have opted-out of traditional Medicare by choosing a Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has important consequences for seniors and for the Medicare program. For many seniors, it has meant substantial additional costs. The supplemental plans also mean additional costs for Medicare. By filling in Medicare's cost-sharing requirements, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increasing Medicare's costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among

seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. The large variations in spending for Medicare mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles to people living in higher medical cost states and states with aggressive practice styles. The Congress and the public are aware of these differences because of the differences in premiums paid to Medicare+Choice plans but seem unaware that the differences in spending in traditional Medicare is now even greater than the variation in Medicare+Choice premiums.

Finally, the provider community has been complaining bitterly about payment inadequacies as well as administrative complexities associated with Medicare. Particular concern has been raised about reduced payments to physicians and whether access to care for seniors is in danger of being jeopardized. Payment rates to physicians were reduced by more than 5 percent for FY2002 and would have been reduced by an additional 4.4 percent next month, had it not been for the action recently taken by the Congress. Even so, payments are expected to decline next year if additional changes aren't made to the way physician payments are calculated. Reductions in payments for nursing homes and home health care have also raised issues of future compromises in care although to date there has not been evidence to suggest access to care has become a problem for seniors. Information on quality is being made accessible where available and the Administration is making the availability of additional quality measures for home care and nursing homes a major priority.

Provider complaints about administrative complexities have been almost as great as their complaints about the levels of payment. Although none of these are new issues, providers have been increasingly vocal about these concerns. Among the many complaints that have been raised—uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment across contractors seems to be at the top of most lists.

In a report released last year, the General Accounting Office (GAO) verified the validity of many of the complaints. Among their findings: information given to physicians by carriers is often difficult to use, out of date, inaccurate and incomplete. The carriers provided toll-free provider assistance and web-based information but only 15 percent of the test calls were complete and only 20 percent of the sites had all the information required. CMS was also criticized for having too few standards for the carriers and for providing too little oversight.

**Prescription Drug Coverage and Medicare Reform**

Although I believe it is important to pass a reformed Medicare program soon and that a reformed Medicare package should include outpatient prescription drug coverage, I believe just adding this benefit to the Medicare program that now exists is not the place to start the reform process. The most obvious reason is that there are a series of problems that need to be addressed in order to modernize Medicare to accommodate the needs of the retiring baby-boomers and to be viable for the 21st Century. To introduce a benefit addition that would substantially increase the spending

of a program that is already financially fragile relative to its future needs without addressing these other issues of reform is a bad idea.

The principles articulated by the President are consistent with the FEHBP model and also the work of the Bipartisan Commission for the Long Term Reform of Medicare. I personally support reform modeled after the FEHBP where the government's payments on behalf of an individual would not very with the type of plan that is selected. I believe this type of structure would produce a more financially stable and viable program. It would also provide incentives for seniors to choose efficient health plans and/or providers and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I recognize that the FEHBP is controversial with some in Congress, particularly because of the difficulties the Medicare+Choice program has been having. It is important to understand, however, that many of the problems of the Medicare+Choice program reflect the decision by the Congress to encourage the expansion of plans in underserved areas by limiting the increase for plans with most of the enrollees to 2 percent per year, even though their costs were increasing at a rate that was several times that amount. In addition, Medicare+Choice plans have faced additional regulatory burdens as well as substantial uncertainties about future changes in regulation. Combined, these factors have helped transform what had been a vibrant, rapidly growing sector into a stagnant and troubled one.

A second reason not to add a drug benefit without further reforms to Medicare is the difficulty of correctly estimating the cost of any new, additional benefit. Our past history in this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972, for example, was underestimated by several-fold. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of two and one-half between the time it was initially proposed and the time it was repealed.

These issues taken together reinforce my belief that adding a prescription drug benefit to traditional Medicare without further modernizing the program is unwise. A better strategy would be to agree on the design of a reformed Medicare program and to begin to implement changes now. At a minimum, it is likely to take at least two years to produce the regulations needed to build the infrastructure needed for a reformed Medicare program.

As we contemplate a Medicare program for the 21st Century, it is also important to understand that the people who will be reaching 65 over the next decade as well as the baby boomers have had very different experiences compared to today's seniors. Most of them have had health plans involving some form of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors

as a different generation, with different experiences, with potentially different health problems and if we start soon, with different expectations.

**The Administration's Medicaid Proposals**

The Administration's proposal for Medicaid distinguishes between mandatory populations and mandatory benefits on the one hand and optional populations and optional benefits on the other. Mandatory benefits for mandatory groups are kept as they are under current law, but substantial new flexibility is provided for the optional populations and optional benefits. In addition, increased funding of $12.7 billion is provided over the first seven years although the program is to be budget neutral over 10 years. Much of the flexibility that is currently available through the waiver process would be provided directly to the states under the Administration's proposal. There are also specific incentives for supporting individuals with disabilities who are currently institutionalized that could be served in home or community-based settings.

Although the specifics of the programs have not yet been presented in detail, the proposal discusses the use of an acute-care health insurance allotment and a long-term care and community services allotment. The amounts in each would be based on spending in 2002 with level of effort requirements imposed on the states.

**The Rationale for Providing More Flexibility to Medicaid**

States are experiencing severe fiscal pressure from their Medicaid programs. These pressures are coming from three different directions. First, many states proactively increased spending on Medicaid during the 1990's by expanding the populations covered, the benefits offered and the rates paid to providers. Second, state revenue declined substantially more than initially anticipated in 2001 and 2002. Third, the counter-cyclical nature of Medicaid has produced some additional expansion in the Medicaid rolls. The Administration is proposing to provide some of the flexibility that has been previously available to the states through the waiver process directly to the states to increase their ability to cope with these additional fiscal pressures. It should be noted that this increased flexibility is being proposed only for the optional populations and benefits and not for the mandatory populations or benefits.

The expectation is that the flexibility being proposed will allow states to make the best use possible of their Medicaid funds in an era of unusually constrained resources. As in the case of SCHIP, states would be able to work more directly with private insurers and provide premium support for recipients enrolled in private plans. States would be able to tailor their programs to meet the needs of individuals throughout the state in ways that are not easily possible under current Medicaid rules, such as with the "state-wideness" requirement. This is not fundamentally new flexibility that is being offered the states since the waiver process provided what was essentially a fully flexible program but rather a less hassled and costly way to achieve a similar flexibility.

There is an additional reason for the Federal government to provide greater flexibility to the states in return for more total control over Federal monies for optional populations and benefits. States in previous periods of fiscal pressure have shown great creativity in developing ways to increase Medicaid spending using only increased Federal dollars. Provider taxes and voluntary donation strategies in the early 1990's, disputes over disproportionate share spending and intergovernmental revenue transfers later in the decade and current debates about upper payment limits are among the examples that come to mind. These are inappropriate ways for the Federal government to make additional monies available to the state. The outcomes of these strategies do not represent the results of explicit decisions by the Congress to change the relative shares of Federal to state dollars in Medicaid and the amount of money a state receives is not determined by its own spending on Medicaid nor on the basis of its own fiscal need.

The general direction of the Medicaid policy changes announced by the Administration makes sense. The specifics of the formula and the details of the program will be important determinants of the impact of the proposed change on the states and on the populations that have been traditionally served by the Medicaid program. They should be assessed carefully.